

Date _____

Family Member/Legal Representative

You are being provided this notice to inform you that, for the reasons explained below, you will be transferred or discharged from this facility.

You will be transferred/discharged for the following reason(s):

A list of the permitted reasons for transfer and discharge is found at 42 CFR 483.12(a)(2).

Transfer/Discharge Location (Mark and complete one of the following.)

You will be _____ to the following location
Transferred/Discharged

Placement Location/Facility

on

Effective Date of Transfer/Discharge

OR

The location to which you will be transferred or discharged is unknown at the time of this notice. This nursing facility will take the following steps to ensure a safe and orderly transfer or discharge from the facility.

Bed hold information has been provided to the resident regarding transfer/discharge.

BY: _____ TITLE: _____
Facility Representative Signature

ADVOCATES/ASSISTANCE

For assistance in understanding your rights or filing an appeal, contact the State Long-Term Care Ombudsman:

Tom Sweely
Montana Long-Term Care Ombudsman
P.O. Box 4210
Helena, MT 59604-4210
1-800-332-2272
406-444-7785

If you are developmentally disabled or mentally ill and need assistance understanding and asserting your rights, contact the Montana Advocacy Program:

Montana Advocacy Program
P.O. Box 1680
316 North Park Avenue, Room 211
Helena, MT 59624-1680
1-800-245-4743
406-449-2344

FAIR HEARING RIGHTS

If you disagree with the facility's decision to transfer or discharge you, **you may request a hearing within 30 days** of the date of this letter. A hearing may be requested for you, by a family member, a friend, legal counsel, an advocate, or other representative of your choice. Your request must be mailed or delivered to:

Office of Fair Hearings
Department of Public Health and Human Services
P.O. Box 202953
2401 Colonial Drive, 3rd Floor
Helena, MT 59620-2953

Upon receipt of your timely request, a hearings officer will be appointed by the Department of Public Health and Human Services to hear your case and issue a decision. You will be contacted by the hearing officer regarding scheduling of a hearing. You have the right to represent yourself at the hearing or to use legal counsel, an advocate, a relative, a friend or another person to represent you.

The facility's decision to transfer or discharge you does not affect your Medicaid eligibility. If you have any questions regarding Medicaid coverage of services in the setting to which the facility proposes to transfer or discharge you, please contact your local county office of human services or the Department's Senior and Long-Term Care Division at (406) 444-4077.

REQUEST FOR A FAIR HEARING

If you would like to request a fair hearing, you may fill out the information below and mail it to the Office of Fair Hearings address above.

TO: Fair Hearings Officer. I would like to request a Fair Hearing to appeal the decision to transfer/discharge me from a nursing facility.

Please print information other than signature.

_____	_____
Nursing Facility Name	Resident's Name

Requestor's Name (if different than resident's)	
_____	_____
Requestor's Signature	Date of Request
_____	_____
Requestor's Address	Telephone Number